STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
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N.L 33-1293

Date December 8, 1993

Index: Budget:
County Claiming/Reimbursement

To California Children Services (CCS) Program Independent County Administrators and Children's Medical Services Branch (CMS) Regional Offices

Subject: Revised Diagnostic, Treatment, and Therapy Expenditure Claim Forms for Independent Counties

The change in claiming administrative costs initiated in fiscal year 1992-93 necessitated a change in the reporting mechanism for diagnostic, treatment, and therapy expenditures and the claim for reimbursement. As a result the "Diagnostic, Treatment, and Therapy Claim for Reimbursement" and the accompanying "Quarterly Report of Expenditures" forms have been revised to accommodate these changes. The new format for reporting expenditures and claiming reimbursement will improve the CMS Branch/CCS program's ability to capture specific cost data.

Counties that process and issue warrants for payment of claims for services for CCS-authorized services are to use the newly revised "Independent County Quarterly Report of Expenditures/Diagnostic and Treatment" and "Claim for Reimbursement--Independent County". Beginning with the third quarter of fiscal year 1993-94, these revised forms must be used for claiming reimbursement. However, you may use these forms for any quarter prior to this commencement date.

The forms are to be used by all independent counties except for counties that forward CCS-authorized claims through the Medi-Cal fiscal intermediary, Electronic Data System for payment. At this time, these revised forms are applicable to all independent counties with the exception of Riverside County CCS program.

The revised format provides for separate reporting of all Medical Therapy Program expenditures except for vendored therapy. The reporting of the therapy program expenditures is on a newly created form, "Independent County Quarterly Report of Expenditures Medical Therapy Program". Vendored therapy expenditures will be reported as Code 50 on the form MC 2155B: "Treatment: Report of Care and Expenditures". As this code does not appear on the existing form, it is necessary to add "Code 50", as shown on the enclosed Attachment C.

Please replace "Claim for Reimbursement--Independent Counties" (MC 2153), "Independent County Quarterly Report of Care and Expenditures" (MC 2154), and the "Support Data--Therapy Programs" (MC 2406) with the new forms.

If you have any questions regarding the use of these forms, please contact Harvey Fry (916) 654-0565.

Maridee Gregory M.D.

Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosures

CHILDREN'S MEDICAL SERVICES (CMS)
CALIFORNIA CHILDREN SERVICES (CCS)

FORMS: Independent Counties Claiming for Reimbursement and Reporting of Expenditures

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12/03/93

INDEPENDENT COUNTY
CLAIM FOR REIMBURSEMENT
CHILDREN'S MEDICAL SERVICES/CALIFORNIA CHILDRENS SERVICES
DIAGNOSTIC/TREATMENT/THERAPY

STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES

CLAIM OF:_____ COUNTY FISCAL YEAR:

FOR EXPENDITURES INCURRED FROM:_____ TO:_____

PURSUANT TO SECTIONS 248-275 OF THE HEALTH AND SAFETY CODE AND RELATED LEGISLATION

		(STATE USE ONLY)			(COUNTY USE ONLY)
	(PART I)	9X-52431-4855-702-85..	DIAGNOSTIC	(50%)	$_____
2.		9X-52431-4855-702-29....	TREATMENT	(50%)	$_____
3.		9X-52440-4855-702-28....	BONE MARROW	(100%)	$_____
4.			SUM		$_____
5.		9X-52431-4855-702-86....	ASSESSMENT FEES	(50%)	$_____
6		9X-52431-4855-702-29....	ENROLLMENT FEES	(50%)	$_____
7.		9X-52433-4855-702-90....	REPAYMENTS	(75%)	$_____
8.			SUM		$_____
9.			SUBTOTAL	=	$_____
		9X-52431-4855-702-29....	ADJUSTMENTS	(+ or -)	$_____
11.			ADJUSTED SUBTOTAL	=	$_____
12	(PART II)	9X-52440-4855-702-28....	MEDICAL THERAPY	(+	$_____
13.			TOTAL REIMBURSEMENT CLAIMED		$_____

CERTIFICATION:

I hereby certify under penalty of perjury: that I am the duly authorized officer of the claimant herein; and that this claim is in all respects true, correct and in accordance with the law; that the material, supplies or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; that the original invoices, payrolls, or other vouchers in support of this claim are on file with the County.

_____ (_____)_____ Date:_____
Contact Person (Type or Print Name) Telephone Number

_____ By:_____
Authorized Official (Type or Print Name and Title) Signature of Authorized Official

(SEE INSTRUCTIONS ON REVERSE SIDE)

FOR STATE USE ONLY DATE TO CONTROL: SCHEDULE #:

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INSTRUCTIONS FOR COMPLETING INDEPENDENT COUNTY CLAIM FOR REIMBURSEMENT

A GENERAL INFORMATION

1. This claim for reimbursement summarizes the quarterly expenditures for diagnostic, treatment and therapy services.

2. Attach one copy (each) of the "Independent County Quarterly Report of Expenditures, Diagnostic and Treatment" and the "Independent County Quarterly Report of Expenditures, Medical Therapy Program" to this original claim and mail to:

   Children's Medical Services
   California Children Services
   Administration Unit
   714 P Street, Room 350
   Sacramento, CA 95814

   Reimbursement will not occur unless the claim and both quarterly reports are submitted together.

3. Claims for reimbursement are to be submitted by the independent county within 60 days of the end of each quarter.

B. INSTRUCTIONS FOR COMPLETING THE CLAIM FOR REIMBURSEMENT

Heading:

Enter the county name, fiscal year and the beginning and ending date of the quarter being reported.

PART I - (*)FROM THE "Independent County Quarterly Report of Expenditures, Diagnostic and Treatment", complete the following items.

1. Diagnostic - (*)Enter one-half of the amount shown on line 1g.
2. Treatment - (*)Enter one-half of the amount shown on line 2h
3. Bone Marrow - (*)Enter total amount shown on line 9.
4. Sum - Enter the sum of the amounts shown on lines 1, 2, and 3 from this form.
5. Assessment - (*)Enter one-half of the amount shown on line 4b.
6. Enrollment - (*)Enter one-half of the amount shown on line 5b.
7. Repayments - (*)Enter total amount shown on line 11.
8. Sum - Enter the sum of the amounts shown on lines 5, 6, and 7 from this form.
9. Subtotal - Subtract line 8 from line 4 on this form and enter the amount.
10. Adjustments - (*)Enter the net amount shown on line 13. Indicate positive or negative net amounts by circling the appropriate plus (+ or minus (-) symbol.
11. Adjusted Subtotal - Enter the sum of/or difference (whichever is appropriate) between lines 9 and 10 from this form.

PART II - (*)FROM THE "Independent County Quarterly Report of Expenditures, Medical Therapy Program", complete the following.

12. Medical Therapy - (*)Enter the amount shown in SECTION IV, SUMMARY OF THERAPY PROGRAM EXPENDITURES, line 5.
13. Total Reimbursement Claimed - Enter the sum of lines 11 and 12 from this form.

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY

Department of Health Services
Children's Medical Services

INDEPENDENT COUNTY
QUARTERLY REPORT OF EXPENDITURES
DIAGNOSTIC AND TREATMENT
FISCAL YEAR _____

_____COUNTY

Expenditures from_____ _____
per H & S Code Sections 248-275.

PART I - SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

1. Diagnostic Expenditures
   - a. MC 2155A $_
   - b. MC 2156B (+) $_
   - c. Subtotal = $_
   - d. Uncashed Warrants $_
   - e. Miscellaneous Revenue (+) $_
   - f. Subtotal = $_
   - g. Adjusted Gross Diagnostic Expenditures = $_
2. Treatment Expenditures
   - a. MC 2155B $_
   - b. MC 2155B Vendored Therapy (+) $_
   - c. MC 2156B (+) $_
   - d. Subtotal = $_
   - e. Uncashed Warrants $_
   - f. Miscellaneous Revenue (+) $_____
   - g. Subtotal = $_
   - h. Adjusted Gross Treatment Expenditures = $_____
3. Sum of Adjusted Gross Diagnostic and Treatment Expenditures = $_____
4. Assessment Fees a. Receivables $_____ b. Collected $_
5. Enrollment Fees a. Receivables $_____ b. Collected (+) $_
6. Total Fees Collected (-) $_____
7. Total Net Diagnostic and Treatment Expenditures = $_____
8. State Match (50%) State $_
9. Bone Marrow Transplant(s) (-600,000 population) (+) $_
10. Total State Amount $_
11. Family Repayments (75% State Share) Collected (-) $_
12. Subtotal Reimbursement to County = $_____
13. Adjustments a. Due County (+) $_ b. Due State (-) $_ + or -) $_____
14. **Total Reimbursement to County** = $_____

15. County Contact Person _____ (Type or Print Name) (____)_____ Telephone Number _____ Date

Attach a copy of this form to the original CLAIM FOR REIMBURSEMENT, DIAGNOSTIC/TREATMENT/THERAPY.

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INSTRUCTIONS FOR COMPLETING INDEPENDENT COUNTY CLAIM FOR REIMBURSEMENT

A. GENERAL INFORMATION

1. This claim for reimbursement summarizes the quarterly expenditures for diagnostic, treatment and therapy services.

2. Attach one copy (each) of the "Independent County Quarterly Report of Expenditures, Diagnostic and Treatment" and the "Independent County Quarterly Report of Expenditures, Medical Therapy Program" to this original claim and mail to:

   Children's Medical Services
   California Children Services
   Administration Unit
   714 P Street, Room 350
   Sacramento, CA 95814

   Reimbursement will not occur unless the claim and both quarterly reports are submitted together.

3. Claims for reimbursement are to be submitted by the independent county within 60 days of the end of each quarter.

B. INSTRUCTIONS FOR COMPLETING THE CLAIM FOR REIMBURSEMENT

Heading:

Enter the county name, fiscal year and the beginning and ending date of the quarter being reported.

PART I - (*)FROM THE "Independent County Quarterly Report of Expenditures, Diagnostic and Treatment", complete the following items.

1. Diagnostic - (*)Enter one-half of the amount shown on line 1g
2. Treatment - (*)Enter one-half of the amount shown on line 2h
3. Bone Marrow - (*)Enter total amount shown on line 9
4. Sum - Enter the sum of the amounts shown on lines 1, 2, and 3 from this form
5. Assessment - *)Enter one-half of the amount shown on line 4b
6. Enrollment - (*)Enter one-half of the amount shown on line 5b.
7. Repayments - (*)Enter total amount shown on line 11
8. Sum - Enter the sum of the amounts shown on lines 5, 6, and 7 from this form.
9. Subtotal - Subtract line 8 from line 4 on this form and enter the amount.
10. Adjustments - (*)Enter the net amount shown on line 13. Indicate positive or negative net amounts by circling the appropriate plus (+) or minus (-) symbol.
11. Adjusted Subtotal - Enter the sum of/or difference (whichever is appropriate) between lines 9 and 10 from this form.

PART II - (*)FROM THE "Independent County Quarterly Report of Expenditures, Medical Therapy Program", complete the following.

12. Medical Therapy - (*)Enter the amount shown in SECTION IV, SUMMARY OF THERAPY PROGRAM EXPENDITURES, line 5.
13. Total Reimbursement Claimed - Enter the sum of lines 11 and 12 from this form

INSTRUCTIONS FOR COMPLETING INDEPENDENT COUNTY QUARTERLY REPORT OF EXPENDITURES DIAGNOSTIC AND TREATMENT

A. GENERAL INFORMATION

1. CCS independent county programs are reimbursed for the state share of diagnostic and treatment expenditures on a quarterly basis.

2. One copy of the Quarterly Report of Expenditures, Diagnostic and Treatment is to be attached to the original "Independent County Claim for Reimbursement for Diagnostic, Treatment and Therapy" and mailed to: **Children's Medical Services, California Children Services, Administration Unit, 714 P Street, Room 350, Sacramento, CA 95814** within 60 days of the end of each quarter.

3. The monies reported on the Quarterly Report of Expenditures shall be based on actual expenditures and/or receipts during the quarter being reported.

B. INSTRUCTIONS FOR COMPLETING THE QUARTERLY REPORT OF EXPENDITURE FORM

Heading:

Enter the fiscal year, county name and the beginning and ending date of the quarter being reported.

Part I - SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

1. Diagnostic Expenditures

   a. MC 2155A - Enter the "CCS Total" dollar amount as identified on form MC 2155A (Attachment A) for the quarter being reported.

   b. MC 2156B - Enter the total dollar amount of clinic costs for diagnostic services (i.e. codes 81 and/or 96) as identified on form MC 2156B (Attachment B) for the quarter being reported.

   c. Subtotal - Enter the sum of lines 1a and 1b.

   d. Uncashed Warrants - Enter the total dollar amount of all uncashed warrants returned to the county in the quarter being reported.

   e. Miscellaneous Revenue - Enter the total dollar amount of other revenue received in the quarter being reported (such as: provider overpayments, insurance payments, third party liability settlements, etc).

   f. Subtotal - Enter the sum of lines 1d and 1e.

g. Adjusted Gross Diagnostic Expenditures - Subtract line 1f from 1c and enter the amount.

2. Treatment Expenditures

a. MC 2155B - Enter the "CCS Total" dollar amount as identified on form MC 2155B (Attachment C) for the quarter being reported. NOTE: Vendored therapy services (Code 50) are to be reported in item b. Bone Marrow transplant costs for counties with populations less than 600,000 shall only be reported in item nine.

b. MC 2155B Vendored Therapy (Code 50) - Enter the total dollar amount identified by Code 50 on the MC 2155B CCS Report of Treatment expenditures for the quarter being reported. Code 50 represents expenditures for physical and occupational therapy services provided at hospitals or private offices in lieu of services provided by county employed therapists in a Medical Therapy Unit (MTU).

c. MC 2156B - Enter the total dollar amount of clinic costs for treatment services (i.e. code 89) as identified on form MC 2156B (Attachment B) for the quarter being reported. NOTE: Medical Therapy Team conference expenditures are to be reported on the Medical Therapy Program expenditure claim form.

d. Subtotal - Enter the sum of lines 2a, 2b, and 2c.

e. Uncashed Warrants - Enter the total dollar amount of all uncashed warrants returned to the county in the quarter being reported.

f. Miscellaneous Revenue - Enter the total dollar amount of other revenue received in the quarter being reported (such as: provider overpayments, insurance payments, third party liability settlements, etc).

g. Subtotal - Enter the sum of lines 2e and 2f.

h. Adjusted Gross Treatment Expenditures - Subtract line 2g from 2d and enter the amount.

3. Sum of Adjusted Gross Diagnostic and Treatment Expenditures

Enter the sum of lines 1g and 2h.

4. Assessment Fees

*a. Receivables - Enter the entire fiscal year to date outstanding amount due for assessment fees.

b. Collected - Enter the amount of assessment fees collected for the quarter being reported.

5. Enrollment Fees

*a. Receivables - Enter the entire fiscal year to date outstanding amount due for enrollment fees.

b. Collected - Enter the amount of enrollment fees collected for the quarter being reported.

6. Total Fees Collected

Enter sum of lines 4b and 5b.

7 Total Net Diagnostic and Treatment Expenditures

Subtract line 6 from 3 and enter the net amount.

8. State Match (50%)

Enter one half of the amount shown on line 7.

9. Bone Marrow Transplant(s)

A county with a population of 600,000 or less and who meet all the criteria in Health and Safety Code, Section 273 shall report the costs, and maintain documentation, for bone marrow transplants that have been approved by the Regional Office Medical Consultant. All costs reported in this line item are 100 percent state reimbursable. Counties who do not meet this definition are to report their bone marrow transplant expenditures as part of their Treatment Expenditures.

10. Total State Amount

Enter the sum of lines 8 and 9.

11. Family Repayments

Enter the State's 75% share of family repayments collected through the end of the quarter being reported.

12. Subtotal Reimbursement to County

Subtract line 11 from line 10 and enter the total.

13. Adjustments

Enter any adjustments in a. and/or b. Calculate and enter the net amount. Indicate positive or negative net amounts by circling the appropriate plus (+) or minus (-) symbol.

NOTE: Counties shall attach an explanation of the adjustments reported in this category. An example may be a correction of a previous quarterly expenditure claim.

14. Total Reimbursement to County

Enter the sum of/or difference (whichever is appropriate) between lines 12 and 13.

15. County Contact Person, Telephone Number, Date

Enter the name of the person responsible for completion of this report. Type or print the person's name, telephone number, and date the report was completed.

The amounts due in the Assessment and Enrollment Fee receivables block are not used by the State to calculate the amount owed to the county. It is used by State staff for projection of fee revenues only.

INDEPENDENT COUNTY
QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
FISCAL YEAR _____

Expenditure from _____ to
Per Health & Safety Code
Sections 248-275

COUNTY:_____

PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

SECTION I. COUNTY EMPLOYED MTU STAFF

1 NAME	2 CLASSIFICATION	3 MONTHLY SALARY	4 FTE PERCENT	5 EXPENDITURES PAID FOR QUARTER

6) Total Personal Services	$ _____
7) Staff Benefits @ _____%	$ _____
8) Other	$ _____
9) Travel Expenses	$ _____
10) TOTAL COUNTY STAFF EXPENDITURE	$ _____

SECTION II. CONTRACT THERAPISTS

1 NAME	2 JOB TITLE	3 HOURLY RATE	4 NUMBER OF HOURS	5 EXPENDITURES PAID FOR QUARTER

6) TOTAL CONTRACT STAFF SERVICES	$ _____

SECTION III. OTHER EXPENDITURES

1) MISC. EXPENDITURES	$ _____
2) MTU CONFERENCE CHARGES	$ _____
3) TOTAL MISC. EXPENDITURES	$ _____

SECTION IV. SUMMARY OF THERAPY PROGRAM EXPENDITURES

1) Sum of Therapy Program Expenditures	$ -
2) Adjustments	$ -
3) GRAND TOTAL OF THERAPY PROGRAM EXPENDITURES	$ -
4) County Share (50%)	$ _____
5) State Share (50%)	$ _____

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Attach a copy of this form to the original CLAIM FOR REIMBURSEMENT, DIAGNOSTIC/TREATMENT/THERAPY.

COUNTY _____

INDEPENDENT COUNTY
QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
FISCAL YEAR .

Expenditures From: ___ To: ___
Per Health & Safety Code
Sections 248-275

PART II. Supplement to Summary Report of Therapy Expenditures Page __ Of ___

SECTION I. COUNTY EMPLOYED MTU STAFF

1 NAME	2 CLASSIFICATION	3 MONTHLY SALARY	4 FTE PERCENT	5 EXPENDITURES PAID FOR QUARTER
6) TOTAL PERSONAL SERVICES (COUNTY STAFF)				$

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INDEPENDENT COUNTY
QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
FISCAL YEAR

Expenditures From: _____ To:
Per Health and Safety Code
Sections 248-275

COUNTY _____

PART II. Supplement to Summary Report of Therapy Expenditures Page___Of___

SECTION II. CONTRACT THERAPISTS

1 NAME	2 JOB TITLE	3 HOURLY RATE	4 NUMBER OF HOURS	5 EXPENDITURES PAID FOR QUARTER

6) TOTAL CONTRACT STAFF SERVICE EXPENDITURES $_____

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INSTRUCTIONS FOR COMPLETING INDEPENDENT COUNTY QUARTERLY REPORT OF EXPENDITURES MEDICAL THERAPY PROGRAM

A. GENERAL INFORMATION

1. CCS county programs are reimbursed for the state share of therapy expenditures on a quarterly basis.

2. Therapist or supporting staff time claimed on the CCS administrative claim *may not be claimed* on this form.

3. One copy of the Quarterly Report of Expenditures Medical Therapy Report is to be attached to the original "Independent County Claim for Reimbursement for Diagnostic, Treatment and Therapy" and mailed to **Children's Medical Services/California Children Services, Administration Unit, 714 P -Room 350, Sacramento, CA 95814** within 60 days of the end of each quarter.

4. The county claim for reimbursement for medical therapy program expenditures is to be reported on Line 12 of the state form entitled, "Independent County Claim for Reimbursement". This amount is obtained from Section IV, Line 5 of the "Independent County, Quarterly Report of Expenditure, Medical Therapy Program" form.

5. A supplemental form is provided for use when the space allowed on the Quarterly Report of Expenditures is insufficient for the number of staff to be claimed. The supplemental form(s) are to be attached to the Independent County Quarterly Report of Expenditures, Medical Therapy Program and submitted with the Independent County Claim for Reimbursement for Diagnostic, Treatment and Therapy.

B. INSTRUCTIONS FOR COMPLETING THE QUARTERLY REPORT OF EXPENDITURES FORM

Heading:

Enter the fiscal year, county name and the beginning and ending date of the quarter being reported.

C. PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

SECTION I. COUNTY EMPLOYED MEDICAL THERAPY UNIT (MTU) STAFF

1. **Name (Type or Print)**

Enter the names of all county employed therapists and supporting staff (i.e.,therapy aides, therapy assistants, etc.) allocated by the State who provided direct patient care in the MTU and/or directly supervised therapists for the reporting period. If the names of county employed or contract therapy staff exceed the space allowed on the Quarterly Report of Expenditures form, indicate on the form, "See Attached Supplements", and use the "Supplement to Summary Report of Therapy Expenditures" form (Attachment I and/or II, as appropriate). Total the salary expenditures on Line 6 of that form for each staff type (county or contract). Carry the total expenditure forward from Attachment(s) I and/or II to Line 6 of the Quarterly Report of Expenditures form.

2. **Classification**

Enter the appropriate civil service classification corresponding to each name.

3. **Monthly Salary**

Enter the total monthly salary for each employee.

4. **Full Time Equivalent (FTE) Percent**

Enter the percent of staff time spent providing direct patient care and/or directly supervising therapist(s) for the reporting quarter.

5. **Expenditures Paid for Quarter**

Multiply the monthly salary (Column 3) for each employee by three (for the three months in the quarter). Multiply this sum by the percentage of time (show in decimals) spent (Column 4) in providing direct patient care and enter the total in Column 5.

6. **Total Personal Services**

Enter the sum of all expenditures identified in Section I, Column 5.

7. **Staff Benefits**

Enter the percentage (show in decimals) paid by the county for staff benefits for county employed therapy personnel. Calculate the benefits by multiplying staff benefit percentage (show in decimals) by the total personal services amount on Line 6 and enter the total. *Costs must be normal, reasonable, program related and consistently applied to all employees and must be in conformity with county policy for therapy positions.*

8. Other

For those counties paying an area differential for recruitment purposes, enter the amount of the differential only. DO NOT INCLUDE STAFF BENEFITS IN THIS AMOUNT.

9. Travel Expenses

Enter the total amount of travel expenses for all therapy staff incurred during the reporting quarter. Allowable travel expenses are:

a. Mileage which is defined as reimbursement of therapy staff for travel costs within the county in performance of job related duties.

b. For in-service training including State sponsored seminars when approved by the county. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State. Costs shall be supported by employee travel expense documents. Travel expenses may include per diem, commercial auto rental, air travel and private vehicle mileage payments.

10. Total County Staff Expenditure

Enter the sum of lines 6, 7, 8 and 9.

SECTION II. CONTRACT THERAPISTS

1. Name (Type or Print)

Enter the names of all therapists contracted by the county to provide services in the MTU for the reporting quarter. For those counties contracting to a company for therapy services, enter the company name.

2. Job Title

Enter the job title of all therapists contracted by the county for the reporting quarter. For those counties contracting to a company for therapy services, enter physical and occupational therapists separately.

3. Hourly Rate

Enter the hourly rate paid by the county for each contract therapist. For those counties contracting to a company for therapy services, enter the hourly rate paid for the physical therapists and the hourly rate paid for the occupational therapists.

4. **Number of Hours**

Enter the number of hours, or fractions thereof, that each contract therapist worked during the quarter. For those counties contracting to a company for therapy services, separately total the number of hours for physical and occupational therapists and enter.

5. **Expenditures Paid for Quarter**

Multiply the hourly rate (Column 3) by the corresponding number of hours for each contractor (Column 4) and enter the total in Column 5.

6. **Total Contract Staff Expenditure**

Enter the sum of expenditures in Section II, Column 5.

SECTION III. OTHER EXPENDITURES

1. **Miscellaneous Expenditures**

Enter the total of all miscellaneous costs incurred for direct service items (such as splinting material, photography, video supplies) for the MTU program for the reporting quarter. ***See glossary for definition of miscellaneous costs.***

2. **MTU Conference Service Charges**

Enter the total MTU Conference charges identified on Form MC 2156-B. Allowable codes are:

Pediatric MTU Conferences: Code 80

Orthopedic MTU Conferences: Code 84

Prothetist or Orthotist: Code 90

3. **Total Other Expenditures**

Enter the sum of Section III, Lines and 2.

SECTION IV. SUMMARY OF THERAPY PROGRAM

I. **Sum of Therapy Program Expenditures**

Add the totals from Section I, Line 10, Section II, Line 6, Section III, Line 3 and enter the sum.

2. **Adjustments**

Enter any adjustments for the reporting period. Calculate and enter the net amount. State whether positive or negative net amounts by placing the appropriate plus (+) or minus (-) symbol.

NOTE: Counties shall attach supporting documentation to substantiate the adjustments reported in this category. An example of an adjustment is a correction of a previous quarterly expenditure claim.

3. **Grand Total of Therapy Program Expenditures**

Enter the sum of/or difference (whichever is appropriate) between Lines 1 and 2.

4. **County Share (50%)**

Enter one half of the amount shown on Line 3.

5. **State Share (50%)**

Enter one half of the amount shown on Line 3.

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Glossary of Terms for the Diagnostic, Treatment and Therapy Quarterly Reports of Expenditures

ADJUSTMENTS - Funds being reported to correct a previous quarterly claim. One hundred percent of the adjustment is reported regardless of whether it is due to the state or the county.

ASSESSMENT FEES - An annual fee to be collected by the county for an individual or family of an active or potentially eligible CCS child who at time of application or renewal is required to pay a $20.00 fee unless such individual or family meets the exceptions as identified in Health and Safety Code, Section 255(d).

BONE MARROW TRANSPLANTS - Funds expended by a county with a population of 600,000 or less for bone marrow transplant services. Costs for these services must meet all the criteria in Health and Safety Code, Section 273.

COLLECTED - Assessment and Enrollment Fees and Family Repayments that have been collected by the county in the quarter being reported.

CONTRACT THERAPY - Physical or Occupational Therapy services provided in a Medical Therapy Unit by other than county personnel who are paid by a formula which includes fringe benefits.

DIAGNOSTIC EXPENDITURES - Funds expended by the county for diagnostic services which were authorized by the county as necessary to confirm or establish the presence of a CCS medically eligible condition.

DIAGNOSTIC REPORT OF CARE AND EXPENDITURES (MC 2155A) - This report is used by independent counties to report detailed information about the specific types of diagnostic services provided through the local CCS program and the costs related to these services. The report is submitted with the "Quarterly Report of Expenditures, Diagnostic and Treatment."

ENROLLMENT FEES - An annual fee to be collected by the county for an individual or family of a child receiving treatment services through the CCS Program, unless the individual or family meets the exceptions as identified in Health and Safety Code, Section 257(f). Enrollment fees are based upon family size and income and adjusted to reflect changes in the federal poverty level.

FAMILY REPAYMENTS - Funds collected by the county based on an agreement by which an individual or family of a child receiving treatment services repays the CCS Program. Family repayments were replaced by enrollment fees in 1991; however, some families have entered into long term agreements and are continuing to repay this obligation. The State is reimbursed 75% of family repayments collected through the quarter being reported.

FIELD CLINIC REPORT (MC 2156B) - This report is used by independent counties to report detailed information about the type and costs of clinics conducted by the county. The cost of a clinic is charged to either diagnostic, treatment, or therapy services on the appropriate "Quarterly Report of Expenditures."

FISCAL YEAR - A twelve month period between settlements of financial accounts. For budget purposes the State's fiscal year is July 1 through June 30.

MEDICAL THERAPY CONFERENCE - The multi-disciplinary health care team meeting, usually held in the Medical Therapy Units, for the purpose of patient examination, treatment planning and discussion of Medical Therapy Program cases.

MEDICAL THERAPY PROGRAM - The medically necessary physical and occupational therapy services and medical conference team services provided by the counties in the public school setting through cooperative efforts of state and local CCS programs with state and local educational agencies.

MEDICAL THERAPY PROGRAM EXPENDITURES - Funds expended by the county for medically necessary physical and occupational therapy services and the medical conference team services provided in the Medical Therapy Unit in a public school.

MEDICAL THERAPY UNIT (MTU) - The actual place in the public school where the medical therapy services are provided.

MEDICAL THERAPY UNIT CONFERENCE DATA - The number of children seen at a Medical Therapy Conference as reported on the Field Clinic Report (MC 2156B) for the reporting period.

MISCELLANEOUS EXPENDITURES - Items purchased to serve individual clients at the MTU, e.g., splinting material, photography/video supplies.

MISCELLANEOUS REVENUE - Revenue received from other sources, i.e., provider overpayments, insurance payments, third party liability settlements, etc.

RECEIVABLES - Funds due, in a fiscal year, for Assessment Fees and Enrollment Fees owed by an individual or family of a child receiving diagnostic and/or treatment services.

TREATMENT EXPENDITURES - Funds expended by the county for medically necessary services provided to children who are determined to meet CCS eligibility requirements and whose services have been authorized by the CCS Program.

TREATMENT REPORT OF CARE AND EXPENDITURES (MC 2155B) - This report is used by independent counties to report detailed information about the specific types of treatment services provided through the local CCS program and the costs associated with these services. The report is submitted with the "Quarterly Report of Expenditures, Diagnostic and Treatment."

UNCASHED WARRANTS - County issued warrants that were payment for services to CCS eligible children and were returned to the county uncashed.

VENDORED THERAPY - Physical or Occupational therapy services provided in either a hospital or private office in lieu of services provided by county employed therapists in a Medical Therapy Unit. Services are paid on a fee for service basis and the data is reported as Code 50 on the MC 2155B report. Vendored Therapy expenditures are reported as a treatment expenditure on the "Quarterly Report of Expenditures, Diagnostic and Treatment" under line 2b.

11/17/93

State of California—Health and Welfare Agency

ATTACHMENT A

Department of Health Services

DIAGNOSTIC
CALIFORNIA CHILDREN SERVICES
REPORT OF CARE & EXPENDITURES

County _____ Tran. Code 2

Quarter Ending _____ Fund Code

Completed By _____

Date _____

File Number	ICD-9 DIAGNOSIS		SERVICES DATA						INSTITUTION SERVICES				PAYMENT DATA	
	a DX Rec. TR c Secondary DX	b Primary DX d Secondary DX	Type Serv.	# Units	Amount Billed	Type Serv.	# Units	Amount Billed	Type Serv.	# Units	Amount Billed	Inst. Code	a CCS Payment c Provider Write-Off	b Insurance Payment d Total Billed
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d

CODE	TYPE OF SERVICE	UNIT
01	Physician Outpatient	# Visits
02	Physician Inpt. Non-Surg	# Visits
03	Physician Inpt. Surgery	# Visits
04	Physician Inpt. (Anesth.)	# Visits
06	Dental Services	# Visits
07	Optometrist	# Visits
08	Social Worker	# Visits
09	Psychologist	# Visits
10	Clinical Nurse Spec.	# Visits

CODE	TYPE OF SERVICE	UNIT
19	Other Professional	# Visits
21	Hospital Inpatient	# Days
22	Hospital Outpatient	# Visits
24	Speech & Hearing Center	# Visits
29	Other Specialized Centers	# Visits

CODE	TYPE OF SERVICE	UNIT
31	Eye Appliances	# Invoices
39	Other Appliances	# Invoices
40	Laboratory	# Invoices
41	X-Ray	# Invoices
42	Blood, Factor, & Product.	# Invoices
43	Drugs/Medication	# Invoices
44	Maintenance & Trans.	# Invoices
45	Medical Supplies	# Invoices
49	Other Services	# Invoices

CCS Total _____

Total Billed _____

Records This Page _____

Page _____

MC 2155 A (2/80)

State of California—Health and Welfare Agency

ATTACHMENT B

Department of Health Services
California Children Services Branch

FIELD CLINIC REPORT
(PROVIDER FLAT FEE)

COUNTY _____

QUARTER ENDING _____

Tran. Code 9
Fund Code 1

COMPLETED BY _____

DATE _____

Clinic Date	Provider Name	Service Type	Number of Hours	Expenditures

TYPE OF SERVICE	TYPE OF CLINIC	TYPE OF SERVICES	TYPE OF CLINIC
80	Physician Services - MTU Clinic	89	Physician Services - Other Clinic
81	Physician Services - Cardiac Clinic	90	Prothetist or Orthotist - MTU Clinic
82	Physician Services - Pediatric Clinic	94	Prothetist or Orthotist - Orthopedic Clinic
83	Physician Services - Plastic Clinic	96	Orthodontist Services - Orthodontia Clinic
84	Physician Services - Orthopedic Clinic	99	Other Non-Physician Services
85	Physician Services - Otology Clinic		

Records this Page

Page

MC 2156B (1/80)

tate of California—Health and Welfare Agency

ATTACHMENT C

Department of Health Services

TREATMENT
CALIFORNIA CHILDREN SERVICES
REPORT OF CARE & EXPENDITURES

County _____ Tran. Code 3

Quarter Ending _____ Fund Code 3

Completed By _____

Date _____

File Number	ICD-9 DIAGNOSIS		SERVICES DATA						INSTITUTION SERVICES				PAYMENT DATA	
	a DX Rec. TR c Secondary DX	b Primary DX d Secondary DX	Type Serv.	# Units	Amount Billed	Type Serv.	# Units	Amount Billed	Type Serv.	# Units	Amount Billed	Inst. Code	a CCS Payment c Provider Write-Off	b Insurance Payment d Total Billed
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d
	a c	b d											a c	b d

CODE	TYPE OF SERVICE	UNIT
01	Physician Outpatient	# Visits
02	Physician Inpt. Non-Surg.	# Visits
03	Physician Inpt. Surgery	# Visits
04	Physician Inpt. (Anesth.)	# Visits
05	Orthodontic Services	# Visits
06	Other Dental Services	# Visits
07	Optometrist	# Visits
08	Social Worker	# Visits
09	Psychologist	# Visits
10	Clinical Nurse Spec.	# Visits
11	Private Duty Nurse	# Visits
12	Priv. Occ. & Phy. Therapy	# Visits
13	Private Speech Therapy	# Visits
19	Other Professional	# Visits
21	Hospital Inpatient	# Days
22	Hospital Outpatient	# Visits
23	Conval. or Rehab.	# Days
24	Speech & Hearing Center	# Visits
29	Other Specialized Centers	# Visits
30	Orthopedic Appliances	# Invoices
31	Eye Appliances	# Invoices
32	Hearing Appliances	# Invoices
33	Wheelchairs	# Invoices
39	Other Appliances	# Invoices
40	Laboratory	# Invoices
41	X-Ray	# Invoices
42	Blood, Factor, & Products	# Invoices
43	Drugs/Medication	# Invoices
44	Maintenance & Trans.	# Invoices
45	Medical Supplies	# Invoices
49	Other Services	# Invoices
50	Vendored Therapy	# Visits

CCS Total _____

Total Billed _____

Records This Page _____

Page _____

MC 2155B (2/80)

CSP